

		FOR BHF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0010637</u></p> <p><b>Facility Name:</b> <u>LASALLE COUNTY NURSING HOME</u></p> <p><b>Address:</b> <u>1380 NORTH 27TH ROAD</u> <u>OTTAWA</u> <u>61350</u>          Number City Zip Code</p> <p><b>County:</b> <u>LA SALLE</u></p> <p><b>Telephone Number:</b> <u>(815) 433-0476</u> <b>Fax #</b> <u>(815) 433-9321</u></p> <p><b>HFS ID Number:</b> <u>69-03333027001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>1945</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>CATHY HARVEY</u> <b>Telephone Number:</b> <u>(815) 433-0476</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/04</u> to <u>11/30/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ <u>02/28/06</u> (Date)</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>CATHY HARVEY</u></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ <u>02/28/06</u> (Date)</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>TAWNIA MACK</u> <u>CPA</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>ECHOLS, MACK &amp; ASSOCIATES, P.C.</u> <u>116 E WASHINGTON, STE ONE, MORRIS, ILLINOIS 60441</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>815-942-3306</u> <b>Fax #</b> <u>815-942-9430</u></td> </tr> <tr> <td colspan="2"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b> </td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>02/28/06</u> (Date)		(Type or Print Name) <u>CATHY HARVEY</u>		(Title) <u>ADMINISTRATOR</u>	<b>Paid Preparer</b>	(Signed) _____ <u>02/28/06</u> (Date)		(Print Name and Title) <u>TAWNIA MACK</u> <u>CPA</u>		(Firm Name & Address) <u>ECHOLS, MACK &amp; ASSOCIATES, P.C.</u> <u>116 E WASHINGTON, STE ONE, MORRIS, ILLINOIS 60441</u>		(Telephone) <u>815-942-3306</u> <b>Fax #</b> <u>815-942-9430</u>	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
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## STATE OF ILLINOIS

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Facility Name & ID Number LASALLE COUNTY NURSING HOME# 0010637 Report Period Beginning: 12/01/04 Ending: 11/30/05

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>104</u>	Intermediate (ICF)	<u>104</u>	<u>37,960</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>104</u>	TOTALS	<u>104</u>	<u>37,960</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>14,526</u>	<u>18,432</u>		<u>32,958</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,526</u>	<u>18,432</u>		<u>32,958</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 86.82%

D. How many bed-hold days during this year were paid by the Department?

NONE (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/01/65

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: N/A Fiscal Year: 12/01/04-11/30/05

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number LASALLE COUNTY NURSING HOME # 0010637 Report Period Beginning: 12/01/04 Ending: 11/30/05

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary		4,889		4,889		4,889		4,889		1
2	Food Purchase		645,323		645,323		645,323		645,323		2
3	Housekeeping	132,690	20,589	11,082	164,361		164,361		164,361		3
4	Laundry	61,359	13,398	56,566	131,323		131,323		131,323		4
5	Heat and Other Utilities			115,852	115,852		115,852		115,852		5
6	Maintenance	186,843	15,995	41,944	244,782		244,782	49,264	294,046		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	380,892	700,194	225,444	1,306,530		1,306,530	49,264	1,355,794		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,261,184	83,977	627,991	1,973,152		1,973,152		1,973,152		10
10a	Therapy										10a
11	Activities	88,034	8,295		96,329		96,329		96,329		11
12	Social Services	51,448			51,448		51,448		51,448		12
13	CNA Training										13
14	Program Transportation		879		879		879		879		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,400,666	93,151	627,991	2,121,808		2,121,808		2,121,808		16
	<b>C. General Administration</b>										
17	Administrative	95,905			95,905		95,905	23,305	119,210		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			16,786	16,786		16,786	(2,581)	14,205		20
21	Clerical & General Office Expenses	106,716	8,989	569	116,274		116,274	30,993	147,267		21
22	Employee Benefits & Payroll Taxes			667,846	667,846		667,846	12,608	680,454		22
23	Inservice Training & Education			1,906	1,906		1,906		1,906		23
24	Travel and Seminar			1,740	1,740		1,740		1,740		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,245	67,245		67,245		67,245		26
27	Other (specify):* SUPPLY			1,298	1,298		1,298		1,298		27
28	<b>TOTAL General Administration</b>	202,621	8,989	757,390	969,000		969,000	64,325	1,033,325		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,984,179	802,334	1,610,825	4,397,338		4,397,338	113,589	4,510,927		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number **LASALLE COUNTY NURSING HOME**

#0010637

Report Period Beginning:

12/01/04

Ending:

11/30/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			147,895	147,895		147,895		147,895			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			147,895	147,895		147,895		147,895			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			4,204	4,204		4,204		4,204			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			952,844	952,844		952,844		952,844			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			957,048	957,048		957,048		957,048			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,984,179	802,334	2,715,768	5,502,281		5,502,281	113,589	5,615,870			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number LASALLE COUNTY NURSING HOME

# 0010637

Report Period Beginning: 12/01/04

Ending: 11/30/05

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

STATE OF ILLINOIS  
LASALLE COUNTY NURSING HOME

Page 5A

ID# 0010637  
Report Period Beginning: 12/01/04  
Ending: 11/30/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

# 0010637

**Report Period Beginning:**

**12/01/04**

**Ending:**

**11/30/05**

[illegible]

## Summary B

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 MAINTENANCE	\$		N/A	\$ 49,264	\$ 49,264	1
2	V	17 ADMIN SERVICES			N/A	23,305	23,305	2
3	V	21 CLERICAL SERVICES			N/A	30,993	30,993	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 103,562	\$ * 103,562	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LASALLE COUNTY NURSING HOME # 0010637 Report Period Beginning: 12/01/04 Ending: 11/30/05

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LASALLE COUNTY NURSING HOME # 0010637 Report Period Beginning: 12/01/04 Ending: 11/30/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization COUNTY OF LASALLE  
 Street Address 707 ETNA ROAD  
 City / State / Zip Code OTTAWA, IL 61350  
 Phone Number ( 815-433-0476  
 Fax Number ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE-COUNTY	DAYS	250	\$ 175,944	\$	70	\$ 49,264	1
2	17	ADMIN-COUNTY	DAYS	250	83,231		70	23,305	2
3	21	CLERICAL-COUNTY	DAYS	250	110,690		70	30,993	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 369,865	\$		\$ 103,562	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest:** (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ \_\_\_\_\_      Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1. Real Estate Tax accrual used on 2004 report.		\$	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$	3																				
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	2000 <table border="1"><tr><td>8</td></tr></table> 2001 <table border="1"><tr><td>9</td></tr></table> 2002 <table border="1"><tr><td>10</td></tr></table> 2003 <table border="1"><tr><td>11</td></tr></table> 2004 <table border="1"><tr><td>12</td></tr></table>	8	9	10	11	12	<table border="1"> <tr> <td></td> <td><b>FOR OHF USE ONLY</b></td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2004 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
8																							
9																							
10																							
11																							
12																							
	<b>FOR OHF USE ONLY</b>																						
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13																					
14	PLUS APPEAL COST FROM LINE 5 \$	14																					
15	LESS REFUND FROM LINE 6 \$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																					

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    LASALLE COUNTY NURSING HOME    COUNTY    LA SALLE

FACILITY IDPH LICENSE NUMBER    0010637

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (    )    FAX #: (    )

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	<b>\$ _____</b>	<b>\$ _____</b>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?           YES           NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

A.

Square Feet:

47,592

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

2

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	GROUND	513,000	1960	\$ 9,950	1
2					2
3	TOTALS	513,000		\$ 9,950	3

Facility Name &amp; ID Number LASALLE COUNTY NURSING HOME

# 0010637

Report Period Beginning:

12/01/04

Ending:

11/30/05

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	104			1965	\$ 480,000	\$		\$	\$	\$ 480,000	4
5				1965	280,000					280,000	5
6				1967	51,675					51,675	6
7				1969	123,087					123,087	7
8				1970	164,927					164,927	8
		<b>Improvement Type**</b>									
9		Building improvements		1966	4,643		30			4,643	9
10		Building improvements		1968	35,441		30			35,441	10
11		Building improvements		1969	9,575		30			9,575	11
12		Landscaping		1970	12,456		20			12,456	12
13		Garage & Blacktopping		1971	22,125		20			22,125	13
14		Blacktop seal		1972	1,487		20			1,487	14
15		Kitchen Fire System		1974	985		25			985	15
16		Fire door & fire detectors & roof section		1975	6,381		30			6,391	16
17		Boil & roof repairs & fire doors		1976	24,443		20			24,443	17
18		Roof repairs & generator & plumbing repairs		1977	28,326		20			28,326	18
19		Roof repairs & cable installation & painting		1978	25,471		20			25,471	19
20		Roof repairs and painting water tower		1979	40,012		20			40,012	20
21		Shower, mixing valve, roof repair, road asphalt, fence		1980	54,262		20			54,262	21
22		Signs, sewer, retubing boiler		1981	31,671		20			31,671	22
23		New boiler, air cndtnr, windows, door alarm, sprinklers		1982	289,413		20			289,413	23
24		Sprinkler system, hydrants, water tank, closet doors, chimney		1983	23,135		20			23,135	24
25		Boiler room, roof repairs, paint in A & B wings		1984	17,164		20			17,164	25
26		Sewer repairs, call page system, telephone, curtains		1985	38,629		20			38,629	26
27		Sewer improvements		1986	182,002	6,067	30	6,067		116,282	27
28		Sewer improvements		1987	62,084	2,069	30	2,069		38,796	28
29		Water tower paint and sidewalks		1989	43,548	1,452	30	1,452		7,368	29
30		Generator, fire line, linen cooler, chimney, roof, arch		1990	269,784	13,489	20	13,489		185,736	30
31		Painting, carpet, chimney, blacktop, water line, trees		1991	36,959	1,848	20	1,848		29,316	31
32		Asphalt driveway, roof arch repairs		1992	4,120	206	20	206		2,530	32
33		Building and land improvements		1993	60,542	3,027	20	3,027		34,811	33
34		Building improvements		1994	104,162	4,514	20	4,514		104,162	34
35		Fixtures		1994	3,037		10			3,037	35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Window project	1995	\$ 293,711	\$ 14,686	20	\$ 14,686		\$ 85,038		37
38	Cement Pad #1	1995	2,750	138	20	138		1,172		38
39	Cement Pad #2	1996	5,330	267	20	267		2,268		39
40	Porch, oxygen room	1996	33,252	1,663	20	1,663		9,977		40
41	Door alarms/ smoke dectector	1996	3,110	156	20	156		2,489		41
42	Fire sprinkler system	1998	169,013	8,451	20	8,451		54,930		42
43	Code alert system	1999	26,004	1,300	20	1,300		11,271		43
44	Water Tower	2000	621,990	31,100	20	31,100		155,500		44
45	Building Improvements	2001	22,718	1,136	20	1,136		4,545		45
46	Emergency Generator	2002	71,896	3,595	20	3,595		10,785		46
47	Water Treatment System	2002	6,203	310	20	310		930		47
48	Water Treatment System	2002	49,440	2,472	20	2,472		4,944		48
49	Water Treatment System RO	2003	12,000	600	20	600		900		49
50	Water Treatment System RO	2004	6,553	328	20	328		492		50
51	Fiber Optic Improvement	2004	14,776	739	20	739		1,108		51
52	Water Treatment System RO	2004	124,767	6,238	20	6,238		9,357		52
53	Water Treatment System	2005	24,524	1,226	20	1,226		1,226		53
54	Water Treatment System	2005	4,328	72	20	72		72		54
55	Sewer	2005	9,747	244	20	244		244		55
56	Manhole	2005	965	28	20	28		28		56
57	Dining Room Blinds	2005	3,331	194	10	194		194		57
58	Sidewalk Improvements	2005	3,584	116	20	116		116		58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,041,538	\$ 107,731		\$ 107,731		\$ 2,644,942		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 649,591	\$ 34,486	\$ 34,486	\$		\$ 723,585	71
72	Current Year Purchases	14,817	1,482	1,482			1,482	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 664,408	\$ 35,968	\$ 35,968	\$		\$ 725,067	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TRANSPORT RESIDENTS	2005 FORD VAN	2005	\$ 58,741	\$ 4,196	\$ 4,196	\$	7	\$ 4,196	76
77										77
78										78
79										79
80	TOTALS			\$ 58,741	\$ 4,196	\$ 4,196	\$		\$ 4,196	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,774,637	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 147,895	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,895	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,374,205	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	PARKING IMPROVEMENTS 1972	\$ 11,751	\$	\$ 11,751	86
87	IMPROVEMENTS G2 1974	4,900		4,900	87
88	AUTO 1994	3,600		3,600	88
89					89
90					90
91	TOTALS	\$ 20,251	\$	\$ 20,251	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2006 \$ \_\_\_\_\_

13. /2007 \$ \_\_\_\_\_

14. /2008 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.  Not necessary	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER CNA _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER CNA _____
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 87,833	\$	1
2	Cash-Patient Deposits	2,616		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	352,587		3
4	Supply Inventory (priced at <u>COST</u> )	11,585		4
5	Short-Term Investments	311,113		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	51,754		8
9	Other(specify): <u>EMPLOYEE'S TRUST</u>	19,796		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 837,284	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,950		13
14	Buildings, at Historical Cost	4,029,549		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	743,400		16
17	Accumulated Depreciation (book methods)	(3,394,456)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,388,443	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,225,727	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 318,717	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,616		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,809		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	145,736		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>EMPLOYEE'S TRUST</u>	19,795		36
37	<u>DUE TO OTHER COUNTY FUNDS</u>	117,945		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 665,618	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 665,618	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,560,109	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,225,727	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 1,471,274</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>PRIOR YEAR ADJUSTMENT</b>	<b>(611)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 1,470,663</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>89,446</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 89,446</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,560,109</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1		Amount	
<b>Revenue</b>			
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,222,866	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,222,866	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,433	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,433	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>PROPERTY TAX REVENUE</b>	1,348,758	28
28a	<b>OTHER INCOME</b>	14,670	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,363,428	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,591,727	30

2		Amount	
<b>Expenses</b>			
<b>A. Operating Expenses</b>			
31	General Services	1,306,530	31
32	Health Care	2,121,808	32
33	General Administration	969,000	33
<b>B. Capital Expense</b>			
34	Ownership	147,895	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,204	35
36	Provider Participation Fee	952,844	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,502,281	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	89,446	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 89,446	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



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Facility Name & ID Number **LASALLE COUNTY NURSING HOME**# **0010637**Report Period Beginning: **12/01/04**Ending: **11/30/05****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,134	1,202	\$ 30,031	\$ 24.98	1
2	Assistant Director of Nursing	1,812	2,083	42,858	20.58	2
3	Registered Nurses	12,260	15,045	288,012	19.14	3
4	Licensed Practical Nurses	16,994	19,737	319,200	16.17	4
5	CNAs & Orderlies	37,353	44,579	496,064	11.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,526	3,172	43,649	13.76	8
9	Activity Director	1,682	1,882	29,857	15.86	9
10	Activity Assistants	5,993	6,654	60,729	9.13	10
11	Social Service Workers	2,648	3,022	47,869	15.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	9,417	11,637	190,894	16.40	17
18	Housekeepers	8,669	10,514	128,856	12.26	18
19	Laundry	3,515	4,450	58,763	13.21	19
20	Administrator	1,004	1,668	48,681	29.19	20
21	Assistant Administrator	1,768	2,000	36,123	18.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,456	4,000	42,714	10.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,791	2,114	32,177	15.22	31
32	Other Health Care(specify)					32
33	Other(specify) <u>UNIT ATTENDANT</u>	6,295	7,266	87,702	12.07	33
34	TOTAL (lines 1 - 33)	118,317	141,025	\$ 1,984,179 *	\$ 14.07	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,626		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,008		44
45	Social Service Consultant	34	1,629		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	55	\$ 4,263		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	198	6,759		51
52	Certified Nurse Assistants/Aides	31,166	616,969		52
53	TOTAL (lines 50 - 52)	31,364	\$ 623,728		53

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership	
Name	Function	%	Amount		
JAN ROHWER	ADMIN	0	\$ 53,825		
CATHY HARVEY	OFFICE MGR	0	42,080		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,905		
B. Administrative - Other					
Description				Amount	
				\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$		
C. Professional Services					
Vendor/Payee	Type			Amount	
				\$	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$		

D. Employee Benefits and Payroll Taxes			Amount
Description			
Workers' Compensation Insurance			\$ 110,112
Unemployment Compensation Insurance			18,921
FICA Taxes			148,734
Employee Health Insurance			223,740
Employee Meals			12,608
Illinois Municipal Retirement Fund (IMRF)*			166,339
TOTAL (agree to Schedule V, line 22, col.8)		\$	680,454

E. Schedule of Non-Cash Compensation Paid to Owners or Employees			Amount
Description	Line #		
		\$	
TOTAL		\$	

F. Dues, Fees, Subscriptions and Promotions		Amount
Description		
IDPH License Fee	\$ 955	
Advertising: Employee Recruitment	11,820	
Health Care Worker Background Check (Indicate # of checks performed 28 )	448	
HANDBOOKS/ DUES	982	
RESIDENT ADV	1,641	
YELLOW BOOK	940	
Less: Public Relations Expense (		
Non-allowable advertising	(1,641)	
Yellow page advertising	(940)	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,205

G. Schedule of Travel and Seminar**		Amount
Description		
Out-of-State Travel	\$	
In-State Travel		
Seminar Expense		
GENERAL TRAINING	1,740	
Entertainment Expense (		
(agree to Sch. V, line 24, col. 8)		
TOTAL	\$	1,740

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number **LASALLE COUNTY NURSING HOME**

STATE OF ILLINOIS

# **0010637**

Report Period Beginning:

**12/01/04**

Ending:

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**11/30/05**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. CO. NURSING HOME \$940
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5-YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,566 Line 4
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 952,844  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 12,608 Has any meal income been offset against related costs? NO Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Firm Name: Echols, Mack & Associates, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.